Glastonbury Surgery Center

Medical Records Release Authorization

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if my health information is used or disclosed, the released information may no longer be protected by privacy regulations issued by the federal government.

Patient Filing Request

Last Name	First Name	MI	Date of Birth / /
Street Address	City	State	Zip Code
Home Phone #	Cell Phone #	Best Time to be Reached	

Type of Information to be Released:

- ☐ Operative Report
- ☐ Anesthesia Record
- ☐ Laboratory Results Requisitioned through GSC
- ☐ Other: ______________________________

Purpose of the Release (*check one box*)**:**

- ☐ Personal Use ☐ Insurance
- ☐ Referral/Consultation ☐ Legal
- ☐ Other: _______________________________

Date(s) of Service:____

I authorize this information to be sent via ☐ Mail ☐ Fax **to**:

Self, Physician, or Third Party Name		Fax #	
Street Address	City	State	Zip Code

The patient or patient's legal representative must read and initial the following statements:

a. I understand that my health care and payment for my health care will not be affected if I do not sign this form. **Initials: _________**

b. I understand that I may see and copy the information described on this form if I ask for it, and that GSC will give me a copy of this form after I sign it. **Initials: _________**

c. I understand this authorization will expire sixty (60) days after I sign this form. **Initials: _________**

d. I understand that I may revoke this authorization at any time by notifying Glastonbury Surgery Center in writing; but if I do revoke it, the revocation will not have any effect on any actions Glastonbury Surgery Center took before it received the revocation. **Initials: _________**

Signature	**Date**
Printed Name	**Relationship if Not Patient**

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